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Symptom presentations of older adult crime victims: description of a clinical sample

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Abstract

Psychological sequelae of interpersonal violence in older adults remain understudied. Existing investigations focused on the clinical presentation of older adults who were traumatized as young adults (e.g., combat veterans). Consequently, little is known about the clinical correlates of trauma in recently victimized older adults. This descriptive study attempt to fill this void by documenting the symptom status and demographic features of 36 treatment-seeking older adult crime victims. Results indicated that older adult crime victims who seek services are a multiply traumatized group. They experienced significant financial, educational, medical, and social stressors that may complicate their clinical picture and treatment progress. Additionally, older adult crime victims experienced moderate-to-severe levels of psychopathology as evidenced by symptoms endorsed on an array of structured clinical interviews and paper-and-pencil measures designed to measure symptoms of Posttraumatic Stress Disorder (PTSD), depression, and panic.

Keywords: Older adult; Elderly; Crime victims; PTSD; Depression; Anxiety

1. Introduction

The psychological effects of trauma on older adults remain understudied. This is particularly the case for experiences involving severe interpersonal violence,

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such as rape or physical assault. In younger adults, emotional sequelae of such violence are typically captured by the diagnosis of Posttraumatic Stress Disorder (PTSD). In order to meet DSM-IV (American Psychiatric Association, 1994) diagnostic criteria for PTSD, one must have experienced ''intense fear, helplessness, or horror'' in response to the traumatic event, and must experience symptoms of intrusion, avoidance, and hyperarousal. Intrusive symptoms involve reexperiencing the traumatic event in the form of recurrent, distressing memories, nightmares, or flashbacks. Avoidance symptoms occur when the traumatized individual makes a concerted effort to avoid thoughts, feelings, or other reminders of the traumatic event. Hyperarousal symptoms are exemplified by hypervigilance, sleep and concentration deficits, anger or irritability, and an exaggerated startle response. If the above symptoms persist for more than a month after the trauma and result in impairment of functioning, a diagnosis of PTSD is warranted.

In addition to interpersonal violence, PTSD may follow exposure to a wide range of traumatic events such as automobile accidents, combat, natural disasters, and life-threatening injuries. In contrast to earlier thinking, these events are relatively common in the general population, with approximately 40–75% of US citizens experiencing some form of trauma during their lifetime (Breslau, Davis, Andreski, & Peterson, 1991; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Kilpatrick, Saunders, Veronen, Best, & Von, 1987; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993).

While empirical investigations of PTSD have proliferated in recent years, studies of the disorder with elderly populations are rare (Averill & Beck, 2000; Falk, Van Hasselt, & Hersen, 1997; Lindesay, 1996; Sadavoy, 1997). Accordingly, little is known about the manifestation of this disorder among older adults. The few existing investigations have focused almost exclusively on combat veterans, holocaust survivors, and natural disaster victims. Not surprisingly, most of these studies examined older adults who were victimized when they were much younger. Relatively few studies involved older adults who experienced recent victimization.

Studies of PTSD in older adults have almost uniformly revealed a very chronic and persistent disorder, characterized by waxing and waning, but not elimination of symptoms over time (Averill & Beck, 2000; Falk, Hersen, & Van Hasselt, 1994; Hyer, Summers, Braswell, & Boyd, 1995; Nichols & Czirr, 1986). Many older combat veterans in the studies reviewed by Averill and Beck were able to mask symptoms by immersing themselves in work and family, thereby avoiding or minimizing traumatic cues and memories. It is not uncommon to find an exacerbation of symptoms in such individuals when they begin to encounter normal stressors of advanced age, such as retirement, failing health, and the deaths of loved ones (Lipton & Schaffer, 1986; Schindler, Speigel, & Milachi, 1992). As Bonwick and Morris (1996) note, ''delayed presentation is more likely to reflect a delay in recognition than a delay in onset'' (p. 1074).

The few evaluations of symptomatology in individuals who experience trauma as older adults have produced mixed findings. Falk et al. (1994) reviewed studies

documenting the impact of natural disasters on the elderly, and asserted that much of the ambiguity in this literature was the result of diverse backgrounds and measures employed by investigators. Specifically, these researchers noted that many early studies highlighting the ''resiliency'' of older adult natural disaster victims used nonstandardized measures and/or measures that did not actually evaluate psychological symptoms and disorders, per se.

Moreover, such early reports of resiliency may have resulted from under-reporting of symptoms by the elderly, or under-diagnosis by clinicians. With respect to the former, older adults are often reluctant to report traumatic events or admit to emotional or psychological difficulties (Comijs, Penninx, Kinpscheer, & Tilbarg, 1999; Kogan, Edeistein & McKee, 2000; Lindesay, 1996). Among reasons cited for lower reporting rates of traumas and symptoms in elderly victim populations are age-related forgetfulness for distant traumas (Norris, 1992), older adults' increased propensity to avoid trauma-related cues and conversations (Nichols & Czirr, 1986), self-blame or concerns about credibility with respect to sexual assault (Falk et al., 1997), and failure to label a crime as such because of misconceptions or rigid definitions (e.g., Lindesay, 1996). For instance, older adults may be more likely to endorse rape myths, such as the notion that rape is something perpetrated by strangers. In such a scenario, an older adult may not view coerced sexual contact by acquaintances or significant others as rape.

In addition to under-reporting by older adult trauma victims, under-diagnosis by clinicians may contribute to observations of resiliency in older adult populations of trauma victims. Specifically, distant past traumatic events may not be considered or recognized as relevant to presenting concerns of older adults (Bonwick & Morris, 1996). Given the previously discussed findings that symptoms of PTSD tend to be very chronic and persistent, it is arguably the case that many instances of PTSD are unacknowledged by clinicians when older adults present for treatment later in life. Moreover, anxiety is often difficult to diagnose in elderly populations because of medical comorbidity (Sheikh & Cassidy, 2000), and the fact that anxiety-related somatic complaints are often ascribed to the normal frailties and maladies of old age (Falk et al., 1997).

Overall, because of problems with diagnosing anxiety in older adults, coupled with this population's reluctance to report traumas and emotional difficulties, the true prevalence of PTSD in older adults is largely unknown at this time. Moreover, contrary to previous assertions of resiliency in older adult populations, there is reason to suspect greater vulnerability to emotional difficulties following exposure to traumatic stressors in this population (Lindesay, 1996). Bachman, Dillaway, and Lachs (1998) reported, for instance, that older victims of assault are more likely to sustain injuries during the assault, and are more likely to require medical care for these injuries. Although older adults are less likely to be the victims of interpersonal violence than younger adults (which may be the result of differences in reporting as well as differences in rate of assault), they are more likely to be injured and require medical treatment (Muram, Miller, & Cutler, 1992).

Given the paucity of research on the responses of older adults to trauma, it is not surprising that very little is known about the clinical and symptom characteristics of those elderly crime victims who do actually present for treatment. Those investigations that have studied older adult crime victims (e.g., Muram et al., 1992) have focused more on trauma characteristics and reporting biases than on clinical presentations. The purpose of the present investigation was to examine the trauma history and emotional sequelae of a sample of treatment-seeking older adult crime victims. To our knowledge, this is the first study to focus exclusively on crime-related symptomatology of older adults. Because such individuals may often be mis-diagnosed by mental health professionals, it is essential to document the clinical presentation of these individuals in order to facilitate diagnosis and treatment decisions. Utilizing data from the Older Adults Clinic at the National Crime Victims Center, our investigation was designed to document trauma history, demographic characteristics, and emotional response of older adult crime victims.

2. Method

2.1. Participants

Data were collected from 36 older adults consecutively admitted for outpatient individual therapy for trauma-related symptomatology. Thirty-five of the 36 participants were female. The mean age of the sample was 62.9 years (S.D. = 9.0). Fifty-three percent were classified as being of low socio-economic status, while 44% were middle SBS. The majority (65%) was unemployed. Thirty-four percent of patients in this investigation reported that they did not earn a high school diploma; 31% had graduated from high school or its equivalent, and 35% had at least some college education. Fully 50% of the sample were divorced or separated and another 19% were widowed. Moreover, 28% of patients reported that they did not have at least two individuals that they could rely on for social support. With respect to psychiatric background, 33% of the sample had a history of inpatient treatment and 20% had a history of outpatient treatment. Sixty-one percent of participants reported a history of domestic violence. Finally, older adult crime victims appeared to have significant health concerns, as 70% reported that they suffered from a ‘‘serious or chronic medical condition.’’

2.2. Measures

Following initial screening for dementia and psychosis by the second author, all participants were interviewed using the Structured Clinical Interview for DSM-IV (SCID) (First, Spitzer, Gibbon, & Williams, 1994). Participants also completed several standardized questionnaires designed to assess various classes of pathology. These included the Beck Depression Inventory (BDI) (Beck, Ward,

Mendelson, Mock, & Erbaugh, 1961), the Geriatric Depression Scale (GDS) (Yesavage et al., 1983), the Beck Anxiety Inventory (BAI) (Beck & Steer, 1990) and the Post Traumatic Stress Disorder Symptom Scale (Self-Administered version) (PSS-SR) (Foa, Riggs, Dancu, & Rothbaum, 1993).The BDI, a 21-item self-report scale, is among the most widely used instruments to measure depression. Beck and Steer (1984) and Gallagher, Nies, and Thompson (1982) demonstrated that the BDI has high internal consistency ($\alpha = .86$ and .91, respectively), and Olin, Schneider, Eaton, Zemansky, and Pollack (1992); found excellent concurrent validity between the BDI and the GDS ($r = .91$).

The GDS (Yesavage et al., 1983) is a 30-item self-rating scale of depressive symptomatology for older adults. Yesavage et al. (1983) demonstrated that the GDS has excellent internal consistency (mean coefficient $\alpha = .94$), high test-retest reliability ($r = .85$), and excellent concurrent validity (with the Zung Self-Rating Depression Scale ($r = .83$) and the Hamilton Rating Scale for Depression ($r = .84$)).

The BAI is a 21-item self rating scale of anxiety symptomatology. Specific symptom clusters have been identified by Beck and Steer (1991) reflecting neurophysiological, subjective, panic, and autonomic dimensions. Beck and Steer (1991), and Steer, Ranieri, Beck, and Clark (1993) demonstrated the instrument's internal consistency and concurrent validity with the Hamilton Anxiety Rating Scale.

The PSS-SR is a 17-item scale that has undergone validation with female victims of sexual assault and contains continuous ratings allowing for sensitive assessment of changes in PTSD over time. Items correspond to DSM symptom criteria for PTSD. Each symptom criterion is rated in terms of frequency or severity on a 0 (not at all or only 1 time) to 3 (almost always or 5 or more times per week) scale. Total scores range from 0 to 51. The measure contains three subscales representing reexperiencing, avoidance, and arousal. Foa et al. (1993) reported a Cronbach's α of .91 for the total scale and a 1-month retest reliability of .74. Concurrent validation with the Impact of Events Scale and the BDI was .81 and .80, respectively. When the SCID for DSM-III-R was used as criterion reference, the PSS-SR correctly classified 86% of subjects.

2.3. Procedure

As part of standard clinic protocol, each participant was interviewed using the SCID-IV and completed questionnaires during the first two sessions. In instances where patients were unable to read, questionnaires were read to them by the clinician and their oral responses were recorded. Also as part of standard clinic procedure, all data were entered into an SPSS database in which participant's identifying information was replaced with a unique record indentifier number. A single master list linking names with identifier numbers was kept by the second author. Data for this study resulted from a review of these clinic records.

3. Results

3.1. Victimization history

The modal trauma for which treatment was being sought was domestic violence (40%). The other types of traumas for which patients sought treatment were sexual assault or rape as an adult (14%), abuse by family member or caretaker (nonspousal) (11%), homicide of a family member (11%), physical assault (9%) and childhood sexual abuse (6%). Nine percent of the sample presented for treatment related to other types of traumatic events.

A substantial majority of patients were first victimized several years earlier, and 69% reported that their initial traumatic experience occurred more than 10 years prior to presenting for treatment at the National Crime Victims Center. Moreover, 42% reported that their first trauma occurred when they were younger than 18 years of age. Interestingly, slightly over one-fifth of patients experienced their first traumatic event within the past year. Although the majority of patients experienced their first traumatic event several years earlier, it would be inaccurate to conclude that older adults presenting for treatment are doing so to address sequelae of events occurring long ago. Nearly three quarters (74%) of the patients also reported being victimized within the past year, and only 29% reported that their most recent victimization was over 10 years prior to presenting for treatment. While a significant proportion (42%) of patients reported being victimized prior to 18 years of age, nearly three-fourths (73%) were victimized as adults. The vast majority of older adults presenting for treatment (89%) reported being victimized after the age of 55.

3.2. Symptom presentation

An examination of mean scores on paper-and-pencil measures of psychopathology indicated that older adults presenting for trauma-related treatment typically experience moderate to severe psychological symptomatology. Specifically, this sample reported significant symptoms of depression on the BDI ($M = 23.9$, S.D. $= 10.1$) and on the GDS ($M = 16.1$, S.D. $= 7.9$). The mean score on the BAI ($M = 21.9$, S.D. $= 14.3$) was in the moderate range, as was the mean score on the PSS-SR ($M = 25.6$, S.D. $= 14.6$).

Not surprisingly, results of the clinical interviews corroborate results of the paper-and-pencil measures. Table 1 illustrates the percentage of patients endorsing each SCID depression symptom. In addition to depressed mood, the most frequently endorsed SCID depression symptoms were sleep deficits, fatigue, and concentration difficulties. Although less frequently endorsed, a substantial minority of participants reported diminished interest in activities, significant weight changes, psychomotor agitation or retardation, feelings of worthlessness, and suicidal ideation. With respect to clinic patients' panic symptoms identified in SCID interviews, the most frequently endorsed symptoms after panic attacks and

Table 1
Percentage of patients endorsing each SCID depression symptom

Symptom	Percentage of patients endorsing
Depressed mood	39
Sleep deficits	47
Fatigue	39
Concentration difficulties	39
Diminished interest in activities	36
Weight changes	31
Psychomotor agitation or retardation	25
Feelings of worthlessness	25
Suicidal ideation	17

worry about the implications of the attacks were accelerated heart rate, shortness of breath, trembling, feeling of choking and fear of ''losing control'' (refer to Table 2). Less frequently endorsed panic symptoms included fear about subsequent attacks, behavioral change related to the attacks, chest pain, nausea, dizziness, derealization, fear of dying, and numbness/tingling sensations.

In response to SCID PTSD questions (Table 3), intrusive thoughts, nightmares, and psychological distress to trauma cues were the most widely endorsed re-experiencing symptoms, as each of these symptoms was endorsed by over a third of patients. One-fourth of patients reported physiological reactivity in response to traumatic cues, and very few participants reported experiencing flashbacks. With respect to the avoidance cluster, avoidance of thoughts, feelings and conversations associated with the trauma, avoidance of people, places and activities associated with the trauma, and diminished interest in significant activities were the most

Table 2
Percentage of patients endorsing each SCID panic symptom

Symptom	Percentage of patients endorsing
Panic attacks	36
Worry about implications of panic attacks	36
Accelerated heart rate	19
Shortness of breath	19
Trembling	19
Feeling of choking	17
Fear of ''losing control''	17
Fear of subsequent attacks	14
Behavioral change related to attacks	8
Chest pain	8
Nausea	11
Dizziness	14
Derealization	11
Fear of dying	8
Numbness/tingling	11

Table 3
Percentage of patients endorsing each SCID panic symptom

Symptom	Percentage of patients endorsing
Re-experiencing symptoms	
Intrusive thoughts	44
Nightmares	33
Psychological distress in response to trauma cues	36
Physiological reactivity in response to trauma cues	25
Flashbacks	8
Avoidance and numbing	
Avoidance of trauma thoughts/feelings/conversations	33
Avoidance of trauma-related people/places/activities	25
Diminished interest in activities	36
Feelings of detachment from others	19
Trauma-specific memory deficits	14
Restricted range of affect	8
Sense of foreshortened future	17
Increased arousal	
Sleep deficits	36
Concentration difficulties	31
Hypervigilance	22
Exaggerated startle response	22
Irritability or outbursts of anger	14

commonly endorsed symptoms. Other avoidance and numbing symptoms endorsed by patients included feelings of detachment from others, trauma-specific memory deficits, restricted range of affect, and sense of foreshortened future. Finally, sleep deficits and concentration difficulties were the most frequently reported arousal symptoms of PTSD, followed by hypervigilance, exaggerated startle response, and irritability or anger outbursts.

4. Discussion

The preponderance of studies examining PTSD in older adults have examined either combat veterans or holocaust survivors. While such investigations are critical in informing treatment decisions for those populations, they do not permit conclusions to be drawn about the manifestation of symptoms in older adults who have experienced recent interpersonal violence. To our knowledge, the present investigation represents the first examination of trauma history and symptom presentation in treatment-seeking, older adult crime victims.

On the basis of demographic information provided by patients, it is clear that many older adult crime victims have very limited resources for dealing with overwhelming effects of violence. Specifically, approximately half of those presenting for treatment were of low socio-economic status and nearly half

did not complete high school. Moreover, more than one-fourth of the patients did not have at least two individuals in their lives on whom they could rely for social support. Given the far-reaching deleterious effects of trauma, it is clear that such financial, educational, and social deficits may present significant barriers to recovery. As such, clinicians should assess for these complicating factors when evaluating and treating older adults.

When this population seeks treatment, it is typically only after repeated victimization, which may have occurred in childhood, late adulthood, or very recently. An alarming 89% of this sample reported traumas occurring after the age of 55. It is unclear whether results of studies evaluating older adults who have been traumatized several years earlier (e.g., combat veterans) can be generalized to multiply and recently victimized older adults. Approximately three-fourths of participants in the present study experienced some form of victimization within the past year, underscoring the importance of routine trauma screening. In particular, interpersonal violence may be very relevant to older adults presenting with symptoms of anxiety and depression, as 40% of participants sought treatment specifically to address symptoms secondary to domestic partner violence and an additional 11% sought treatment for symptoms resulting from (nonspousal) elder abuse.

This is a purely descriptive study of a treatment-seeking sample of older adult crime victims. Hence, the design does not permit inferences about the extent to which older adults are resilient in the face of trauma. Although other investigations have questioned such resiliency on methodological grounds (e.g., Acierno et al., in press) the present study was not specifically designed to address this issue. What is clear from the present data, however, is that those older adult crime victims who do present for treatment experience substantial emotional and behavioral difficulties. Mean scores on paper-and-pencil measures and responses to SCID diagnostic questions attest to this fact, as the average patient reported moderate-to-severe symptoms of depression, anxiety, and posttraumatic stress.

Some of the most frequently reported symptoms were somatic and physical complaints, such as fatigue, shortness of breath, trembling, accelerated heart rate, and sleep deficits. Thus, the modal symptom pattern endorsed by patients in this study reaffirms previous observations (e.g., Falk et al., 1997) that anxiety-related difficulties in the elderly are often manifested in physical complaints. These observations attest to the likelihood that emotional difficulties in an older crime victim population may be erroneously attributed to physical ailments and age-related physical decline.

Complicating this symptom presentation is the fact that 70% of participants reported that they were in fact experiencing chronic serious medical difficulties. In that vein, some emotional difficulties secondary to these medical problems are to be expected. It would be imprudent however to dismiss the moderate-to-severe level of psychopathology reported by patients in this study as normal emotional sequelae of their physical maladies. Regardless, it is certainly easy to see how, in the absence of a trauma history screen, diagnoses of PTSD in this population could be overlooked by clinicians and primary care physicians.

In sum, older adult crime victims who present for treatment are multiple and recently traumatized, and endorse significant symptoms of anxiety, depression, panic, and PTSD. Consistent with previous research, the patients in this sample reported numerous somatic symptoms. This symptom profile increases the likelihood that emotional difficulties incurred by older crime victims will go unaddressed, as these symptoms may be erroneously attributed to age-related physical decline. Because data bearing on the trauma history and symptom presentation of older adult crime victims are virtually nonexistent, this description of a clinical sample fills an important void in the traumatic stress literature. Clearly, much work remains to be done in this area. Future studies should evaluate the extent to which treatment strategies that were developed for younger victim populations are applicable to the elderly crime victim. In particular, the management of somatic symptoms and comorbid medical conditions may be an essential adjunct to standard treatments when working with older adult populations.

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